



**TO BE COMPLETED BY EMPLOYER** Please print or type in black ink only.

COMPANY NAME

[Grid of boxes for company name]

GROUP NO.                      SUBGROUP NO.      BILLGROUP UNIT      DATE OF HIRE (MM/DD/YYYY)                      EFFECTIVE DATE (MM/DD/YYYY)

[Grid of boxes for group and hire dates]

**NEW ENROLLMENT** Check one:

- New group
  - New hire (complete sections A, B, E, G)
  - Loss of other coverage (complete sections A, B, E, G)
  - Other (please specify) \_\_\_\_\_
  - Cancel all coverage (empl. and family) (complete section A)
  - Open enrollment (complete sections A, B, E, G)
  - COBRA (complete sections A, B, E, G)
- Date of event [Grid of boxes]

**PLAN** Check one:

- HMO
- Multi-Choice
- Out-of-Area
- Consumer Choice Option (CCO)
- Deductible Plan with HSA option (Self Only)
- Deductible Plan with HSA option (Family)
- Out-of-Area PPO with HSA option (Self Only)
- Out-of-Area PPO with HSA option (Family)
- Multi-Choice with HSA option (Self Only)
- Multi-Choice with HSA option (Family)

**IF MAKING A CHANGE, COMPLETE THE FOLLOWING:**

**DELETE DEPENDENTS** (Complete sections A, B, E, G)

	DATE (MM/DD/YYYY)
<input type="checkbox"/> Over age limit	[Grid of boxes]
<input type="checkbox"/> Divorce	[Grid of boxes]
<input type="checkbox"/> Deceased	[Grid of boxes]
<input type="checkbox"/> Other (please specify)	[Grid of boxes]

\_\_\_\_\_

**ADD DEPENDENTS** (Complete sections A, B, E, G)

	DATE (MM/DD/YYYY)
<input type="checkbox"/> Birth	[Grid of boxes]
<input type="checkbox"/> Adoption*	[Grid of boxes]
<input type="checkbox"/> Marriage*	[Grid of boxes]
<input type="checkbox"/> Loss of other coverage	[Grid of boxes]
<input type="checkbox"/> Other (please specify)	[Grid of boxes]

**OTHER CHANGES** (Complete sections A, B, G)

Name change \_\_\_\_\_  Address (complete sections A, G)

Previous name \_\_\_\_\_  Telephone (complete sections A, G)

Current name \_\_\_\_\_

**A. EMPLOYEE INFORMATION**

LAST NAME	FIRST NAME	MI	SUFFIX
[Grid of boxes]	[Grid of boxes]	[Grid of boxes]	[Grid of boxes]
SOCIAL SECURITY NUMBER	MEDICAL RECORD NUMBER (IF ANY)	DATE OF BIRTH (MM/DD/YYYY)	MALE FEMALE
[Grid of boxes]	[Grid of boxes]	[Grid of boxes]	[Grid of boxes]

\*Additional documentation may be required.





EMPLOYEE LAST NAME

SOCIAL SECURITY NUMBER

Grid of boxes for Employee Last Name

Grid of boxes for Social Security Number

ADD  DELETE

DEPENDENT  CHILD  OTHER

LAST NAME

FIRST NAME

MI

SUFFIX

Grid of boxes for Last Name

Grid of boxes for First Name

Box for MI

Grid of boxes for Suffix

SOCIAL SECURITY NUMBER

MEDICAL RECORD NUMBER (IF ANY)

DATE OF BIRTH (MM/DD/YYYY)

MALE FEMALE

Grid of boxes for Social Security Number

Grid of boxes for Medical Record Number

Grid of boxes for Date of Birth

Boxes for Male and Female

Primary Care Physician (PCP) Name

PCP ID #

C. Do any of your dependents above live at another address? YES  NO  If yes, please complete the following:

Table with 2 columns: Name(s) (Last, First, MI) and Address

D. Are any of your listed dependents over the maximum age? If yes, please complete the following:

Table with 4 columns: Name(s) (Last, First, MI), Disabled\*, Full-time student\*, Name of college, university, or trade school

E. OTHER COVERAGE INFORMATION

Including yourself, do any of the persons listed above have other coverage? YES  NO

Table with 4 columns: Name, Insurance carrier name, Policy number, Telephone number

Are you or any of your dependants eligible for Medicare? YES  NO

F. Waiver of coverage

By completing this section, I acknowledge that I was given the opportunity to enroll in this plan of group health benefits offered by my employer. I refuse the following:

- Refusal options: All coverage, Coverage for my spouse, Coverage for my children

I understand that if I or my dependents later wish to enroll for any of the coverage(s) refused, I/they will be required to submit an Employee Application and Change Form, and coverage may be subject to late enrollee provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all appropriate boxes)

- Reasons for refusal: other group coverage sponsored by my employer, other group coverage sponsored by my spouse's employer, other group coverage sponsored by another organization, other reasons (please explain)

\*Please provide name of carrier:

\*Plan number:

Telephone number:

G. Important: Your application cannot be processed without your signature. Please read the back of this form before signing. I acknowledge by my signature that the information I have supplied on this form is true and correct, and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the reverse sides.

Employee/Applicant signature Date Employer signature Date

\*Additional documentation may be required.





**THIS IS YOUR APPLICATION FOR MEMBERSHIP**

**MEMBERS**

This is your application for enrollment. Please complete the reverse side of the application and submit it to your company's personnel office. Thank you for your interest in Kaiser Permanente, the nation's health care leader for nearly 60 years. We look forward to meeting your health care needs for many years to come.

**EMPLOYERS**

Mail the original application to: Kaiser Foundation Health Plan of Georgia, Inc. · P.O. Box 921012 · Fort Worth, TX 76121-1012

**EMERGENCY CARE**

If you have an emergency, call **911** or go to the nearest emergency room. An emergency is any sudden, severe illness or injury that jeopardizes life or health and that would lead a reasonable person with no medical training to seek immediate attention. For follow-up care, call us at **(404) 365-0966** locally or **1-800-611-1811** long distance.

**MEMBER CONFIDENTIALITY**

Kaiser Permanente collects various types of nonpublic personal information, including information contained in your health records, personally identifiable information, and financial information. Such nonpublic personal information may be collected from you and other sources in order to provide health care services, customer services, and fulfill legal and regulatory requirements, among other things.

Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of nonpublic personal information, including policies related to access to medical records.

Kaiser Permanente may collect, use, and share nonpublic personal information when medically necessary or for other purposes as permitted or required by law. Nonpublic personal information will not be released to third parties including your employer, researchers, or the government

without you or your authorized representative's consent, except as may be permitted or required by law.

All Kaiser Permanente employees and physicians are required to maintain the confidentiality of our Members' nonpublic personal information. This obligation is addressed in policies, procedures, confidentiality agreements, and Principles of Responsibilities. All providers with whom we contract are also required to maintain confidentiality.

You may request, in writing, to inspect your own medical record. You may request a copy of your medical record as allowed by law. There may be a fee for copies provided to you. You may also request, in writing, to amend information in your medical record to enhance its completeness and accuracy. Original medical record documentation will not be deleted, however. Your request to review or amend your medical records should be submitted to the medical record department located in the medical facility that you regularly visit.

If you have questions about our policies and procedures to maintain the confidentiality of nonpublic personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses nonpublic personal information, please call our Member Services Department, Monday through Friday from 8:30 a.m. to 9 p.m., and Saturday and Sunday from 8 a.m. to 2 p.m. at **(404) 261-2590**.

I hereby apply for enrollment for myself and eligible family dependents listed on the reverse side and I agree that the information listed is correct. Any intentional material misstatement or omission of information will be considered a misrepresentation and may be the basis of later termination or rescission of coverage issued on the basis of the submitted information, without liability to Kaiser Foundation Health Plan of Georgia, Inc. (Health Plan), Kaiser Permanente Insurance Company (KPIC), and The Southeast Permanente Medical Group, Inc. (Medical Group).

I understand that if the application is accepted by Health Plan and/or KPIC, as applicable, the benefits for which we will be eligible will be in accordance with the *Group Agreement* and/or *Group Policy* applicable to the type of plan for which we are enrolled. If I am enrolling through my employer, I authorize deductions for amounts necessary to pay my Health Plan and/or KPIC coverage. I authorize Health Plan and/or KPIC, as applicable, Medical Group and/or CCN, as applicable, to provide my medical information, and the medical information (including but not limited to substance abuse, behavioral health, HIV/AIDS and confidential information) of any person included under my coverage, to each other, to other health care providers and to insurers as necessary and permitted by law, for purposes including but not limited to: underwriting and rate setting; the provision of care; conducting quality assurance, peer review, or utilization review; the administration of the *Agreement*; and the investigation and settlement of claims. I also consent to the assignment of benefits which I may have in circumstances where a party other than Health Plan and/or KPIC may be responsible for all, or a portion of, the cost of services provided to me. These consents shall remain in force and effect for the duration of my membership in Health Plan and/or KPIC, as applicable.